TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Laurence Ligon, M.D.

Respondent Name
Federated Service Insurance Company

MFDR Tracking Number
M4-16-0925-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This request was in response to a $150.00 reduction of the $1,400.00 for the DDE performed on April 21, 2015."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's position as stated on the EOR is that the bill for DOS 04/21/2015 was correctly reimbursed based on 4 units rather than 6 units as billed. The carrier therefore maintains that it correctly reimbursed the services in question."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2015	Designated Doctor Examination	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- Comment: “NOTES INDICATE 4 IMPAIRMENT RATINGS PER TEXAS WORKERS COMP GUIDELINES. BODY STRUCTURES INCLUDING SKIN (FACE, SCALP, HEAD), SPINE AND PELVIS (CERVICAL AND LUMBAR SPINE), UPPER EXTREMITIES AND HANDS (SHOULDER), AND LOWER EXTREMITIES INCLUDING FEET (THIGH, HIP).”
- Comment: “WE HAVE RECEIVED YOUR REQUEST FOR ADDITIONAL PAYMENT FOR THIS DISABILITY EXAMINATION. AS NOTED ON THE ORIGINAL PAYMENT, WE HAVE DETERMINED THAT ONLY 4 UNITS WOULD BE ACCURATE: BODY STRUCTURES INCLUDING SKIN (FACE, SCALP, HEAD), SPINE AND PELVIS (CERVICAL AND LUMBAR SPINE), UPPER EXTREMITIES AND HANDS (SHOULDER), AND LOWER EXTREMITIES INCLUDING FEET (THIGH, HIP), THEREFORE, PAYMENT WAS MADE CORRECTLY AS $650.00 FOR THE MMI/IR EXAM WITH RANGE OF MOTION, PLUS $150 FOR EACH AREA: $150 X 4=$600.00. THERE WILL BE NO ADDITIONAL ALLOWANCE AT THIS TIME.”
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3), “The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.” The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that:

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
   (i) Musculoskeletal body areas are defined as follows:
   (I) spine and pelvis;
   (II) upper extremities and hands; and,
   (III) lower extremities (including feet).
   (ii) The MAR for musculoskeletal body areas shall be as follows…
   (II) If full physical evaluation, with range of motion, is performed:
   (-a-) $300 for the first musculoskeletal body area; and
   (-b-) $150 for each additional musculoskeletal body area.
   (D) …
   (i) Non-musculoskeletal body areas are defined as follows:
   (I) body systems;
   (II) body structures (including skin); and,
   (III) mental and behavioral disorders.
   (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
   (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

   Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the cervical spine; lumbar spine; left shoulder; left hip; left thigh; contusions of the face, scalp, and head; concussion; and post-concussion syndrome. See below for MAR calculations:

Examination	AMA Chapter	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Cervical Spine (ROM)	Musculoskeletal System	Spine & Pelvis	$300.00
IR: Lumbar Spine (ROM)			
IR: Left Shoulder (ROM)		Upper Extremities	$150.00
IR: Left Hip (ROM)		Lower Extremities	$150.00
IR: Left Thigh (ROM)			
IR: Face/Scalp/Head Contusions	Skin	Body Structures	$150.00
IR: Concussion/Post-Concussion Syndrome	Nervous System	Body Systems	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$900.00**
Total Exam			**$1,250.00**

2. The total MAR for the disputed services is $1250.00. The insurance carrier paid $1250.00. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	February 18, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.